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ABSTRACT

In an attempt to address health and social needs of at-risk children, recent reform efforts have pushed for collaboration of community based agencies and schools. The location of an adolescent health clinic on an inner city high school campus and the resultant opportunity for collaboration provides a case study. The role of the teacher and the implications of such collaboration for teachers are explored from the teacher's point of view. Questions studied include how teachers perceive their role in collaboration to meet the health and social needs of the student-at-risk; the nature of events, conditions, and forces that shape that role; and the consequences of their actions. Twelve teachers participated in the survey. Movement toward collaborative roles for teachers is chronicled as crises in the classroom force change and teachers respond by expanding their role. New "scripts" evolve and new boundaries are established. Neo-institutionalism provides a framework for understanding both the emergence of new roles and the critical points of connection as the culture of the school adapts. (EMK)

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The Call for a New Script:

Teachers' Role in Collaboration

to

Meet Health and Social Needs

of a

Diverse Inner City High School Population

AERA Paper

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S PALMER

The Research Problem

In an attempt to address health and social needs of at-risk children, recent reform efforts have pushed for collaboration of community based agencies and schools. While the models for such collaboration vary, the idea of integration of services emerges as a key concept. The implementation of such collaboration necessarily involves teachers and has implications for their role and practice. The pace of this movement has outstripped our understanding of what such collaboration means for teachers. As a result, a gap exists concerning the role of the teacher in this collaborative process often set up by policymakers and administrators and thrust upon schools by streams of funding and placement of community programs on site.

What does such collaboration mean to teachers? Crowson and Boyd (1996, p.256) write "Recognizably, school staff members, particularly teachers, are likely to be asked to change their roles under collaboration." These researchers quote Melaville and Boyd (1993, p.72) who suggest that "[teachers] must....see 'themselves' in different ways, 'recognize other actors in children's development', 'be open to revised interpretations of learning, and rethink their own roles in relation to children's behavior'." Little and McLaughlin suggest "[r]eform initiatives have pressed teachers toward collaboration...with a fervor that far outstrips our present understanding of the conditions, character and consequences of such relationships" (1994, p.2). While Adler's (1994) claim is that people not organizations collaborate, therefore heightening the focus of the teachers' role in collaboration with staff from agencies "outside" school, Smylie and Crowson (1996) go a step further and counter the "people to people" argument with Powell and DiMaggio's (1983) contention that individuals cannot easily be separated from the iron cages of their institutions. Smylie and Crowson (1996) would agree that while people do the work of

collaboration, the institutional context acts to either constrain or promote their efforts. Turning from a focus on constraints imposed by institutions, Mawhinney (1994, p.326) directs her work to understanding the impetuses for "strategic efforts at collaboration by schools" and the extent to which these efforts result in change in organizational structures in the schools.

Although this is a case study and limited to one school setting, this inquiry is an attempt to add to the base of information regarding collaboration by providing insight from the teachers' vantage point in the move toward collaboration where an adolescent clinic operated by a local health department is co-located on an inner city high school campus . This exploratory study looks at the environmental circumstances which prompt teachers' actions and how these forces and the resultant changes made by teachers work to ingrain collaboration into the school setting rather than hold back the potential success of this reform effort. Analysis of the process promises to reveal new and repeated ways of acting on the part of the teachers - the construction of new scripts and the shaping of an extended role. Propositions from the emerging theory of "neo-institutionalism" are presented as they are relevant to the findings.

The methodology and the questions that guide the qualitative approach of this inquiry are explained in this paper. The initial questions were: How do teachers perceive their role in collaboration to meet the health and social needs of the student at-risk? What are the events, conditions, forces that shape their role? What are the consequences of their actions?

The bottom-up investigation of this collaboration promises to provide insights at the level of delivery of services into what happens after authorities create such a merger and the

resultant effect of the actions taken by the teachers. The conclusions and implications for future research are discussed.

The Theoretical Concepts

The emerging theory on neo-institutionalism is the backdrop for this inquiry. Neo-institutionalism defines institution as "a social order or pattern that has attained a certain state or property; institutionalization denotes the process of such attainment" (Jepperson, 1991, p.144). Order or pattern refers to standardized interaction sequences that are habitually reproduced. Within this definition is enveloped a notion of roles and scripts. While the assumption of role theory is that "the organizational or societal expectations control the actions of individuals in a given position " (Guskin and Guskin 1970, p.1), the concept of script denotes "behavior patterns and sequences called up by specific roles or situations" (Scott 1995, p.23 from the work of Schank and Abelson 1977). Scripts represent what is chronically said and done as the actors go about their work. Drawing from economic, political and sociological traditions, neo-institutionalism provides a way of thinking about organizations with attention to the "way action is structured and order made possible..." (Powell and DiMaggio 1991 p.11).

Neo-institutionalism supports the idea that individuals can actively create their own scripts and meanings within their role designation. Scott (1995) in discussing neo-institutional sociology writes "rather than focusing on the constraining force of norms, cognitive theorists point to the importance of scripts : guidelines for sensemaking and choosing meaningful actions (See Schank and Abelson 1977; Lord and Kernan 1987). In this regard, individuals can act purposefully in pursuit of their own interests and beliefs -

"rather than meekly submitting to the constraints of the surrounding social structure" Scott, 1995 p.24).

Mawhinney (1994) concurs as she writes that "collaboration is after all, a form of organization, one that may change the established procedures, the constituent rules, and the cultural elements that define schools as they are conventionally structured" (p.324). She suggests that rather than reflecting on the constraints which inhibit efforts at collaboration that a look at the "strategic interventions" in the move toward collaboration be explored. She writes "we need to learn more about the strategic actions of single organizations such as schools, that are engaged in collaborative initiatives which may change their institutional practices and organizational forms" (p.326).

In her work, Mawhinney analyzes the "strategic efforts to promote community collaborative effort to enhance the life chances of students" (p.324). Her efforts shift to an approach that explores the essential elements that promote collaboration. This inquiry builds on such an emphasis and attempts to identify factors in one such established case, in particular, to reveal efforts on the part of teachers in the move toward collaboration. While teachers may follow scripts as set forth by the traditions of their profession, they can adapt or construct new scripts under certain circumstances. The teacher then is a critical element in the change of the organization and in creation of a new institution - the collaborative effort. The teachers' perspective, therefore, can provide insights into the failure or success of this reform effort.

Neo instituionalism provides a framework for understanding the impetus for the teachers actions. Cibulka (1996) suggests that "A strength of institutional theory is that it can focus on the interpenetration of organizations and their environments, and how strategies for controlling those environments must shift to accommodate the environmental

changes" (p. 10). If schools can be considered as open systems, then the environment is a factor in shaping the way the organization works; the interaction of the actors within the organization can be viewed from the context of what is happening in the classroom, the school and the community. While institutions "represent continuity and persistence...to the extent that they are carried forward..." (Scott 1995 p.9), the environmental conditions are continually shifting and creating pressure. Neo-institutionalism recognizes that as the environment pushes in upon the institution it can create demands for a new order or pattern. Neo-institutionalism views the environment as pushing into the organization so as to influence the actors. The actions of the teachers therefore can be understood by looking at the circumstances which press in upon then as they attempt to fulfill their role.

This model supports the notion that teachers in the school setting need not be limited by the roles prescribed but as teachers experience pressures on the organization from forces in the environment, they can adapt and shift to newly constructed scripts. As these scripts becomes habitual, they contribute to formation of an expanded role. As teachers' actions are repeated, the teachers become instrumental in change. Teacher engagement then becomes strategic in changing the form of the organization into one which denotes a collaboration.

In this initial inquiry, the data gives evidence to the emergence of a new institution called collaboration - an expanded role for teachers - defined by educators working with school based non-educators for the benefit of students in the school setting. Four assertions from neo-institutionalism theory have particular relevance to the findings in this study:

#1. Change when it does occur is likely to originate from the periphery of the organizational field and can be in response to growing demand for unmet services. To the extent new forms are successful, change [or a new pattern] is introduced into organizational populations (Powell 1991 p.198).

Powell suggests that organizations may respond to demands in different ways based on the heterogeneity of the environment. For example, when there are other resources present, there is more likelihood for input that can lead to new ways of doing things. So to speak, the iron cages get shaken. Also, in circumstances where an organization becomes limited in its ability to meet the demands of its diverse population, conditions may prompt innovation that brings change.

#2. Legitimation "explain[s] or justif[ies] the social order in such a way as to make institutional arrangements subjectively plausible" and "to motivat[e] actors to enact actions by locating them within a comprehensible, meaningful world" (Scott 1991, p.169 quoting Wuthow et al. 1984 p. 50).

Scott (1995) defines legitimacy "not a commodity to be possessed or exchanged but a condition reflecting cultural alignment, normative support or consonance with relevant rules or laws" (p.45). He states "What is taken as evidence of legitimacy varies by which elements of institutions are featured" (Scott, 1995, p.47). While the effect of legitimacy on organizational vitality may vary for different types of population, Scott (1995) discusses the Baum and Oliver (1992) study that reveals that individual organizations with linkages that provide legitimacy were "more likely to survive" (p. 110). Scott (1995) also cites recent studies (Hannan and Freeman,1989; Ranger-Moore, Banaszk-Holl, and Hannan, 1991) which show that life chances of institutions appear to increase with legitimacy that stems from being legally sanctioned (p.110). From the cognitive perspective, prevalence of the form is a way to understand legitimacy. The assumption is that legitimacy "comes from adopting a common frame or reference or definition of the situation....[therefore] prevalence...is a good indicator of the 'taken for grantedness' of a social form or practice (Scott, 1995, p.47).

#3. The process of attaining a new pattern or order may be a function of the positive feedback that adaptive responses and strategic efforts generate. (Powell, 1991, p. 193).

In discussion of organizational procedures and forms that persevere, Powell (1991) defines a path-dependent process as "one {where} important influences upon the eventual outcome are exerted by small fortuitous events...A key feature common to this process is increasing returns, positive feedback" (p. 193). The path-dependent process helps to explain the persistence of institutions - how practices reproduce themselves. As practices and activity sequences are repeated they form patterns or orders which can turn into institutions.

#4. Institutions are taken for granted in the sense that they are both treated as relative fixtures in a social environment and accounted for as functional elements in that environment (Jepperson, 1991, p.147).

When a particular activity or practice makes sense and is understood as having its place and purpose in particular circumstances, there is an element of acceptance by the actors. The action appears as the way things are done and seems to be no longer questioned. Therefore, it persists. There is a notion that the action has meaning within the organization.

This study concentrates on the forces which prompt creation of new scripts and an extended role by teachers and consequences of these actions as they contribute to development of a new institution - collaboration. Teachers are pressured to find new ways to work within the milieu created by the conditions that surround them. As teachers stretch and strain to accommodate the circumstances, they construct scripts and establish new routines. Rather than being held back by the way things have always been done, they respond not to an iron cage of constraints, but to a cage that is shaken. They look to new ways to carry on their work. In this way, teachers are instrumental in reshaping their role. As teachers repeat the patterns over and over again, they support the notion of collaboration within the school setting.

This research seeks to confirm existing propositions and to uncover possibilities for new statements as they relate specifically to the role of the teacher in the process towards the institutionalization of school-community collaboration to better life chances of children.

The Background

A brief history of the placement of a clinic operated by a local health department on an inner city high school campus provides insight into the process. In an effort to address health and social needs of an underserved adolescent population in the area, a member of the health department staff first approached the school, about ten years ago, with the idea of writing a grant for funding in response to a national Request For Proposals for school based clinics. The school principal at that time, the school nurse, and a newly formed school site council welcomed the idea. Pressures upon the school had intensified. The school population had mushroomed and reflected a mix of recent immigrants, families living in poverty, increased trend in drug use and accelerated rates of teen pregnancies. With input of school and health department, a proposal was submitted, but denied due to lack of wider community representation. The momentum, however, continued. An advisory committee was formed with representatives from community and members of the school site council. Another proposal was submitted - this time to the city - to pilot a satellite mini-clinic that would offer services two days a week with part time staff and supervision on loan from the nearby health department's area clinic. The city and health department agreed to the proposal. Meetings held at school and with the community prior to the vote provided input which ultimately resulted in school board approval. This event marked the beginning of a historic event for the school, the district, the city and the state - the first health clinic in a public school setting.

The official arrangement for this collaboration stipulated that the health department would lease space at the school and operate the mini-clinic out of the area health center. A private foundation paid for remodeling; job descriptions were written for clinic staff; and parental consent for comprehensive services were obtained for individual students. Staff from the health department combined with an advisory made of teachers, school staff and representatives from the community finalized plans after a decision had been made to place the clinic on site. In spite of controversy and objections by some teachers and members of the community at large, the adolescent clinic became a reality and was situated prominently in the front hallway, next to the counselors and adjacent to the main office. The doors were opened to teens during the instructional day as well as before and after school hours.

Presently, the adolescent clinic has expanded to a full service agency with three full time staff consisting of a Nurse Practitioner, a mental health counselor and administrative assistant. There appears to be no formal structure for the collaboration other than a simple lease agreement. There is no written document such as a memo of understanding that officially describes the school's role or the teachers' relationship with the clinic. There is no forum for regular meetings or protocol for communication on behalf of the students between the classroom teachers and the clinic staff. There is no inservice for teachers to provide information on the operation of the clinic and/or its place in the school. There are no roles or responsibilities written or prescribed for teachers. To all appearances, the adolescent clinic operates independently of school structure and activity. However, for access to students during school time and establishment of the practice for comprehensive services, clinic staff depend upon a working relationship with teachers.

The adolescent clinic has been in operation now for approximately eight years. This study assumes that such an established case can yield data that can further

understanding of strategic efforts of teachers in the move toward collaboration where a community agency provides health and social services on site during the school day.

Research Questions and Methods

Collaboration subsumes that there is some linkage or joining together of work to achieve some purpose. This case study is an attempt to explore how teachers interact with and make sense of a particular joining together - a community health clinic co-located at a school to provide services throughout the instructional day for benefit of students. The overall thrust of this study is to discover what meaning this collaborative effort holds for teachers in this setting by asking them questions. This approach is based on Patton's (1980) writing on qualitative research, "It is not possible to observe how people organize their world and the meanings they attach to it, so we have to ask people questions about those things (p.197). Therefore, the use of questions to gain understanding of the teachers' view provides entry to the source of data: Teachers and informants - clinic staff and support staff - were asked questions that included: How do you describe your (teachers') role and interaction with the students in need of health and social services - past, present and what do you anticipate in the future? How would you describe your (teachers') role and interaction with the adolescent health clinic staff? What factors influence your (teachers') role and interaction with the students, with the adolescent clinic staff?

Data was collected from three related sources: semi-structured interviews, observations and documents. The major source were accounts of the six teachers selected from a list of nominations supplied by the principal and clinic Nurse Practitioner. The nominations represented a continuum from more to less teacher interaction with clinic

activity. Names of respondents finally selected demonstrated a range of background and involvement and were known only to the researcher. For purposes of triangulation, three ancillary support school staff and three adolescent clinic staff served as informants to provide their perspective on the teachers' role. The span of time that teachers had been at the school ranged from five to approximately twenty years so that experiences were well grounded and represented some longevity. Classroom subjects represented were English (3), Mathematics (2), and Special Education (1) so teachers interviewed were providing daily academic instruction to students. Ancillary support staff selected were head school counselor, alcohol and drug counselor, and school nurse. All three adolescent clinic staff were interviewed: the Nurse Practitioner was new on site with one year at the school; the mental health counselor; and administrative assistant had been with the clinic since implementation of the pilot project.

Each of the twelve respondents participated in an individual semi-structured interview that lasted approximately one hour. The interview guide as described by Patton (1980, p.200) was used to gain access to the teachers' thoughts and experiences as well as collect information from informants to confirm the findings from teachers. This approach allowed for probes and questions in a more conversational style, yet had the benefit of pre-determined topics for focus. Interviews were transcribed and initially coded into broad descriptive categories.

A second source was derived from observations of school context and in particular, interaction of students, faculty and Teen Health Center staff in and around the adolescent clinic. With staff permission and as unobtrusively as possible, the researcher noted the coming and going of students, faculty and staff in and out of the clinic and recorded highlights of conversations overheard. This intentional immersion in the setting heightened awareness of the people and activity that surround the clinic. The researcher then

incorporated descriptive field notes into reflective write-ups. This process became another way of "rather than studying people, to learn from the people" as mentioned by Glesne and Peshkin (1992, p.42).

The third source were documents related to the initiation and on-going operation of the adolescent clinic. Such documents included minutes of the school adolescent advisory committee, health department memos, school district memos, opinion paper from Attorney General's Office, Lease Agreement, and guidelines for the adolescent clinic staff roles and responsibilities. Zelditch (1962) explains that such works represent and give evidence of what occurred at some time and place when and where the researcher was not present. These works demonstrate what information the participants wanted to deposit in some formal record. Erickson suggests that this type of evidence can show "lines of influence"(1986, p.127).

As the data was compiled, the researcher developed a coding system to label the data into broad categories for on-going analysis. The coding system was reviewed and refined as the analysis continued. The codes provided a way to organize units of meaning and combine data in the search for patterns and themes. As stated by Miles and Huberman (1994) "Codes are used to retrieve and organize the chunks..." (p.57). The researcher also wrote reflective write-ups throughout the process, often after an interview, as well as analytic memos to summarize and move into analysis during the collection of data. In an attempt to work further with the data, the researcher created a display matrix. Miles and Huberman (1994) discuss the idea of a display format as a way to visually examine and "eyeball" data in an attempt to order the data (p. 93).

Findings: Movement Toward Collaborative Roles

Findings that emerge from this exploratory study reveal informal patterns of teachers' engagement in the move towards collaboration. First, particular forces come into play to challenge the teachers' role. A sense of crisis surrounds the teacher as she attempts to provide instruction and care for students in the classroom and along with this circumstance, possibilities emerge. Second, teachers respond in new ways of interaction and thereby create new scripts that extend their role with students. Third, the teachers' actions contribute to the emergence of a new institution - collaboration - where educators work with non-educators in the school setting for the benefit of the students in need. The evidence shows that absence of formal structures do not constrain collaboration, but rather, pressures from the environment stimulate a sequence of interactions between teachers and students and between teachers and clinic staff which promote the collaboration. As the teachers repeat newly constructed scripts and habitually extend their role, they are strategic in the attainment of a new pattern - collaboration.

Challenges to Teachers' Roles

Three major forces in the environmental context challenge teachers' roles and create an impetus for change in urban high schools. The first is the crisis created by circumstances in the students' daily lives. The second is the effect of these crises conditions on the teachers' work in the classroom. The third are the possibilities which emerge for addressing the problematic situation through the array of services available through the adolescent health clinic positioned on site. Factors which contribute to teachers' understanding and influence the teachers' acceptance of the collaborative arrangement are the perception of legitimacy, perception of quality of staff, and positive feedback from the students. Overall, teachers perception of the interplay between health

and learning influences the teachers willingness to share their students with "outsiders" during class time.

Crisis in Students' Lives: "Less of Everything"

Societal problems are reflected in the classroom and perceived by teachers to create a turbulence in their students' lives. "Angry, depressed, acting out, absent, hurting, withdrawn" - the behaviors often mistaken for discipline problems - are mentioned as indicators of both physical and emotional problems often due to circumstances in the students' living environment. Interviewees talked about students who lack the basic provisions expected to be supplied by parents, as well as students who lack basic parenting itself. Reports of the loss of family relationships is mentioned frequently. One teacher's describes the student population vividly:

> We are seeing in the school-on the whole - groups of immigrant students who are on their own. They don't have parents, they have lost them to war. These kids are working, minimum wage, going to school, just trying to keep their heads above water.

Teachers remarked that it is not surprising to find students who were trying to eek out an existence on their own, falling asleep in class, or to discover thoughts of suicide in students' writing assignments. Overall, there is a sense that needs of students are great and resources limited. When asked to describe students in the school, one of the teachers said

> They have less of everything. There are more coming from single parent families, more from low income families, have less to work with, more into drugs, more drugs going around than there used to be...[They] are more disenfranchised from society. I mean, they don't see any point to it, they don't see that they are going to get anything out of it [going to school and doing well]...[They are] just floating around the streets.

Against this backdrop, the need for adolescent health care and social services is apparent, especially when economics of the students' situations may dictate that such services may

not be otherwise available. The awareness of these life conditions put teachers on the alert for resources that can help their students and at the same time help manage pressures on them as teachers. A look at the demands felt by the teachers is helpful to understand the challenge.

Pressures in Teachers' Professional Lives: "One Big Heap Pile"

There is a pattern throughout the interviews that indicates teachers in the face of high student need are overwhelmed and searching for strategies that will help them cope. To face students who are experiencing upheaval in their lives is demanding for the teachers. One teacher remarked "A lot of energy gets consumed calming things down and trying to get them [students] going academically." Another teacher said, "[The life conditions of the students] makes [teaching] hard, it makes it really difficult." Attention to students' personal needs appears to be a necessary requirement of providing a high school education. Teachers expressed the weight of societal pressures affecting their professional lives.

Nearly all of the teachers talked about their limits. They said they are exhausted - trying to teach five periods a day with 130 - 150 students, many of whom are experiencing stress in their lives and unable to concentrate on learning. Some teachers talked about the strain of trying to handle "a lot of societal problems" that are present in the microcosm of the school and used phrases such as "hundreds of expectations," "too busy," "over scheduled," "overwhelmed," "not trained." The teachers' comments pose the dilemma - "all these problems" in the midst of "erosion of resources." A vibrant young teacher remarked, "It's all one big heap pile." A well seasoned veteran teacher summed it up when he sighed, "I'm tired!"

In the midst of this situation, the teachers, generally, and the ancillary support staff subscribe to the idea that "as much as teaching, we want to make sure students are safe and healthy and [that] their needs are being met as much as we can." To accomplish these goals, teachers realize that they cannot do it alone. As the teachers experience the pressures created by high demands and dwindling resources in the life circumstances of students in their classrooms, they look for others who can help. The resources that are available invite consideration.

Possibilities for Addressing the Crisis: "An Array of Services that Makes Sense"

The presence of an adolescent health clinic operated by the health department in the school building offers possibilities for attending to the student needs and relieving the teachers. Teachers who perceive the crisis in students' lives and the impact on their role in the classroom understand the need for a new strategy - non educators working on-site with students during the school day. For these teachers, collaboration with agencies outside the school district that come onto campus to provide comprehensive health and social services which students can access at school represents a new arrangement. The senior teacher on staff who had seen many challenges to his role through the years expresses it clearly:

> The Teen Health Center is like one more thing that you have at a very important time when everything is falling apart...I mean resources, in terms of funding and stuff like that, class sizes are going to get bigger next year, they [school district] cut budgets here and there and stuff like that, they do less all of the time, so it's [Teen Health Center] a resource that you can bring into play to help your different students.

The clinic offers an array of comprehensive services. Teachers have different ways of describing what they understand the adolescent clinic to be. An illustrative response is "[the clinic is a] little tiny hospital on campus...that can help kids with a variety of problems and [give] access to medical care and advice they might not have so readily." Indeed the range of services is comprehensive. The Nurse Practitioner provides routine

physicals, sports physicals as well as diagnosis and treatment of illness and injury such as flu, colds and sprained ankles. Reproductive health concerns are also given attention. The Nurse Practitioner and Mental Health Counselor assist students with personal problems and facilitate access to resources in the community for chronic disease care, dental care, prenatal and postnatal care, alcohol and drug treatment, suicide prevention, and severe emotional problems. The clinic also has programs which focus on prevention education and positive lifestyle choices, such as smoking cessation and weight control.

Central to operation of the adolescent clinic is the administrative assistant who schedules all appointments for the Nurse Practitioner and signs all students in and out of the clinic from their classes. She creates a climate of caring for students and helps them with filling out forms, and getting referral services. As first point of contact with the clinic, the administrative assistant provides reassurance when needed as well as maintaining an efficient professional setting. Services are provided at no cost to those without insurance, thereby meeting health and social needs of those who may not otherwise have access. Connections for obtaining insurance are provided for families who desire it.

The idea, initiated by an outside agency, of an adolescent clinic positioned on a school site where students can come and go during the instructional day is a new concept for teachers. However, one of the teacher's comments is representative, "Most teachers think it [the clinic] makes sense." The reasons they give are many: students can get almost immediate attention; they don't have to be gone from school to go downtown for professional appointments; students can get matters attended to quickly and be in and out of the clinic in a short time and back to class; medications are also available through the clinic so treatment for illness can begin promptly; students who are experiencing stress in their lives can be seen on the spot and problems can be diffused more quickly; parents do not have to leave work and come to school and take their child to appointments. One teacher

remarked that the school clinic "takes a step out somewhere" and "students can get help for themselves." Clinic staff are committed to obtaining parent/guardian consent for services whenever possible to ensure that students receive comprehensive care. However, there are exceptions. In order to conform to federal and state laws, a new consent for services policy (effective in the 1996-97 school year) states that before providing services to a student, "School health clinics for adolescents must have signed consent from a parent or legal guardian, except in situations where federal and/or state laws allow teens to access treatment without parent/guardian consent (e.g., reproductive heath care, drug/alcohol and mental health counseling)".

Additional Influences on Teachers' Perceptions of the On-Site Clinic

Teachers' perceptions of the adolescent health clinic co-located in the building appear to be based on three main factors. First, most of the teachers accept the on site adolescent clinic as legitimate. The clinic began as a pilot program. Teachers, as part of the early site based management council, as well as community representatives, were invited to participate in early decisions regarding the adolescent clinic in the building. The health department and particularly the area clinic had served the community for years and was known to faculty. The school board voted their approval by way of the agreement to lease space. The city council formalized the city's commitment "to continuing and increasing its support for programs and initiatives that complement the school's district's mission" through adoption of a resolution, later matched with taxpayer funds approved by the voters. The mayor was a leader in the movement to address adolescent needs in the school setting by way of city resources. This history contributed to the teachers' perception of legitimacy of the arrangement.

The second factor is the high quality of the staff. "Competent," "committed," and "incredibly caring" are characteristic descriptors. There is the idea that clinic staff are "the experts" and "a good fit for the job." The clinic staff are reportedly "well known" and approachable by the students. As a result of these perceptions, teachers, in general, trust the clinic staff which fosters relationship in the collaboration. The clinic staff are perceived as serving an important function and having a place in the school.

The third factor which shapes the teachers' opinion is the "Aha" principle based on observation of, and feedback from, the students. Teachers learn about the clinic from students' personal testimony and observation of change in students' lives. The school's head guidance counselor summarizes:

> I guess, our staff learns about those things [the impact of the clinic] as time goes on. They have a kid in their class that's having a melt down. The kid gets some services from a guidance counselor and is referred over to the clinic. The kid seems to be performing better in the school. Aha! Something must be happening down there.

Student response creates a loop that ties teachers into the collaboration and encourages their participation.

In summary, three elements - a sense of legitimacy, perception and responsiveness of a qualified staff who serve a specific function, and positive student feedback - all contribute to make the presence of an adolescent clinic an understandable and acceptable possibility for the teachers. However, this possibility presents a challenge to the teachers' previously scripted role in which teachers focused more formally on the lessons at hand and less on the nature of the student's problems and interactions with non-educators to address these problems.

Teachers Expand Their Roles: "On The Front Line" Plus

The stimuli created by the declining life conditions of the students, teacher overload and the possibilities afforded by presence of a resource that can serve a specific function to alleviate the crisis stimulates a response from the teachers. Based on perceptions of legitimacy, high quality purposely directed staff and favorable student feedback, teachers respond to the challenge of teaching students in need by subtly shifting their role, incrementally extending their interaction with students and clinic staff and yet recognizing boundaries. New linkages are formed.

Recognition of a New Role

The isolation and privacy previously associated with the role of the teacher reveals hesitancy on the part of the teacher to intervene in a student's personal life beyond the classroom and translates into closed doors and little or no interaction with non-educators in management of student problems. Referrals to non-educators have generally been considered beyond the role of the teacher. In the face of the present conditions, however, these expectations appear limiting and constraining. In this study, most of the teachers interviewed perceive their role as going beyond the daily lesson plans and the classroom walls. The discussion with a veteran teacher illustrates:

> Teacher: Teaching is not that big a part of the job. There are a lot of other things that come into play.
>
> Interviewer: Like?
>
> Teacher: Dealing with the stuff we've been talking about...[conditions of kids, lack of resources, increasing demands].

As the person who sees the student on a daily basis, the teacher is in a unique position to initiate the process whereby a student's health and social needs can be addressed. As stated

in the interview with one educator, "Teachers are basically on the front line." The teacher therefore can be instrumental in channeling the student into clinic services.

Redefinition of Teacher - Student Interaction

Data analysis illustrates that the teacher extends his/her role in relationship to the student in order to link the student with the adolescent health clinic. This stretch, built upon care and concern for the student's welfare, becomes the informal infrastructure that pulls the teachers into the collaboration. Subsumed in this "on the front line, plus" role are three scripts which teachers construct. The first is identification of a potential problem. This script is exemplified by the teacher's awareness that the student is experiencing some difficulty beyond the scope of the academic lesson.. The teacher observes, pays attention to what is going on with the student, and notes indicators either obvious or subtle that may be signals of deeper health or social issues. One teacher emphasizes "If somebody has a problem, it's obvious. I mean, if somebody isn't themselves, I don't think they should have to sit in a class."

The second script can be called initiatory intervention, an attempt to step closer in and address the problem. This script is typified by an overture on the part of the teacher who simply asks, "Is there something wrong?" The script may range from "taking the student out of the classroom into the hallway to talk" to "writing a hall pass to send the student out of the classroom down to the Teen Health Center," to releasing the student from class to go to the Teen Health Center either in response to a student request or the clinic's use of the *Request to Report* . Teachers respect this yellow form - in use for what seems to have been forever - as a "symbol denoting something important" that needs attention. Teachers have now extended this school district yellow form previously reserved for "in-house" referrals to include "outsiders." - non school personnel - and communication with

these "outsiders" during the school day. This sequence of activity represents a major shift in the teachers' role even though it appears only as an incremental change. Other typical scenarios which typify the interaction with non-school personnel on behalf of a student are those instances when the teacher goes down to the adolescent school clinic to consult with staff about a student; writes a note requesting that the clinic staff follow up with a student; or responds to clinic staff questions regarding a student.

The third script can be described as supportive maintenance when the student returns to the classroom. This action can be described by what is said and done by a caring adult to encourage the student through understanding and accommodating as necessary for a set time period while the student resolves physical or emotional difficulties. A teacher of long-standing commented:

> [It helps us to know] if a student has attempted suicide or is getting beat up at home...it help[s] us make certain allowances for say, late work or give them extra attention for something that they have lost. It makes [for] flexibility, in terms of our expectations and extra efforts we need to help them be successful...If they are having health problems, ...physical or mental, it interferes...with their work...It's mostly awareness so that teachers can adapt their expectations and their support of that student. I think it doesn't have to be much more than that.

To take advantage of the resources offered by the health clinic co-located on campus means that teachers must first recognize their strategic position, then be willing to engage in a more personal interaction between teacher and student, and also be sensitive to needs of students experiencing difficulty. To reach out in this way for the benefit of the student calls for an expanded relationship of collaboration with non-school personnel who are not educators. These activities represent a new bundle of scripts, ways of acting that define the extended role of the teacher in this setting at this time and under these circumstances. The teachers' stories reveal that for some students, these new scripts, or sequence of actions, provide a lifeline to resiliency in their lives.

For some teachers, there is some conflict however, regarding these emerging scripts as represented by one teacher who strongly opposed the on-site clinic: a dedicated teacher of long standing said

> I see myself as an English teacher. I come here to teach and I come here expecting students to learn. When I am not teaching and when the students are not learning, I don't know why I am here...It's what I do and why I am here....[P]eople seem less convinced these days - on the whole, that schools are for learning academic material and more convinced, at least among a significant number of people in this school, that schools are for addressing social problems. There is a critical mass of people here who do not think that the work that we do daily in the classroom matters as much as the work that is done outside of the classroom.

Regardless of this tension, most teachers interviewed were drawn into the collaborative arrangement because they perceive that their instructional role and the ability of students to engage in learning is affected by what is happening with their students outside of the classroom. These teachers perceive an interplay between student well being and student academic performance.

Boundaries to the Expanded Role: "It's Not My Department!"

Teachers who were interviewed set boundaries with regard to their roles with students and with the adolescent clinic. Analysis of data indicates that teachers do not perceive themselves in the therapeutic role as health or social workers. This view is emphasized by one interviewee who said, "[It's] not my department!" While teachers may be the one with initial contact with the student, it is clinic staff who provides actual service and have professional and practical capacity to focus on the individual student. As said by one teacher, "They're [clinic staff] there for just you, when you are there." The adolescent clinic staff has the training, and professional mandate to provide a therapeutic relationship with the student. The definition of teachers' bundle of scripts centers on linking students with the services.

Teachers' scripts also contribute to a role that enhances student utilization of the adolescent clinic. Analysis of data reveals that teachers reconstruct two additional sequence of actions: (1) understanding and acknowledging what the clinic has to offer and (2) promoting these services by telling students about them. Teachers learn about the clinic as they see and hear of the impact on student lives. While the flow of information is primarily from students to teachers, as interest is heightened, teachers go down to the clinic and find out more about how it works and get acquainted with the staff. This acknowledgment validates a working relationship with non educators as part of the school team. Interviews also revealed that most of the teachers are advocates for the clinic and have adopted the role of informing the students: As said by one teacher,

> One of the things is to try and spread the word that we have a Teen Health Center, that it is a resource if they want it, they don't have to take it, nobody is forcing them to do it, but on the other hand, you get to school and you are sick, it might be real nice to have someplace that you can, that could actually give you some cough drops for your sore throat or maybe something a little bit more specific, assuming you've got parent permission.

These processes are informal, but nevertheless point out that it is teachers who connect students in need with clinic services and staff, and also, teachers who encourage students to enroll, thus building the practice of comprehensive services for the clinic.

The significance of this teacher interaction with the clinic is twofold: First, it means that these teachers are willing to share their students with outsiders, non-educators. Generally speaking, there did not appear to be turf or territorial issues between the teachers and the adolescent clinic staff. Most of the teachers perceive the clinic as fulfilling a role that is needed for the students and one that teachers can not fill.

> "I'm an English teacher. I can only go so far. The clinic can help kids. I can't do that!" "I wasn't trained to deal with that (their problems) and shouldn't have to." "I'm not a social worker."

Most teachers interviewed expressed relief because they said they can "focus on teaching because they know that students who have problems [are being] addressed by someone in the building, and it doesn't have to be them."

Secondly, teachers' willingness to promote the adolescent clinic and release their students was predicated on their attitude regarding time spent out of their classroom. Because there is no class period allocated in the school schedule for students to attend to their need for health and social services, it is unavoidable for them to miss class. Other than drop-ins when classes are not in session, there are two means of access to the clinic: The teacher can either respond to a *Request to Report* from the clinic staff for an appointment, or for attendance in a weekly support group; or, the teacher can issue a hall pass when a student asks to go to the clinic, or shows signs of illness or extreme stress. All teachers interviewed as well as clinic staff and support staff talked about time away from class. Comments fell into two categories: it was either a small cost versus the benefits or the costs outweighed the benefits. Most of the teachers were of former mind set. Their attitude is exemplified with this statement from one of the English teachers:

> It's like, well, it doesn't matter if a kid misses one day of class, if the kid is, you know, HIV positive or is having a diabetic attack and needs to learn how to take care of their new health problem, or health dilemma. It's not wasting time if you save some kid from an unwanted pregnancy or anything. I'm sorry, that's just as important as learning how to, where to put an apostrophe.

The exception was the teacher who questioned the benefits and believed the cost to be too high. She said that "the health clinic removes students from classes and quite often students who most need to be in class." In the interview she shared her concerns about the frequency with which students missed class and the reasons for their absence which she felt often did not warrant time away from the classroom. Feeling powerless against the tide which brought the clinic to the school, she continues at her work and holds on to her view

that the Teen Health Center is not a positive presence on the school site. She prefers that students would be seen off campus, for instance, down the block in the community or if, at the school clinic outside of class time: however, in her concern for students, she stated that if she observes that a student is ill, she will issue a pass to the school nurse who may or may not then refer to the Teen Health Center. Other than this type of situation, she chooses to have a minimal relationship with the clinic.

Except for this teacher who does not endorse the concept of the Teen Health Center on campus, teachers do not view the collaboration as a negative presence. Teachers who perceive student well-being as a goal of school appear to show greater flexibility in allowing students to be out of class. For most, the arrangement is a welcome and necessary linkage.

Consequences of Expanding Role: Creation of an Informal Infrastructure

In the midst of the perceived crisis and challenge present in this setting, teachers construct new scripts to create an expanded role that makes sense and has meaning for them. As a consequence they establish a linkage with the adolescent health clinic staff. A new relationship emerges to provide an informal infrastructure that appears essential for collaboration. This relationship between the teachers and the clinic staff can best be defined as loosely coupled yet strongly bonded. In terms of structure, the school and health clinic are not tied together. There is no formal memo of understanding that spells out the relationship, roles or protocols between the two agencies, the school district and the health department, that placed the adolescent clinic in this high school. The only official document that establishes the clinic at the school site is a simple lease agreement issued by the school district for the space occupied by the health department. The health department pays rent and operates independently of the school. Although the adolescent clinic is

centrally and conveniently located in the front hall, there is no direct phone line to the school. All calls must go out and then come back in, even though the office is just a few steps away. The separate phone lines are a symbol of the separateness of two systems that touch at one brief point and then diverge.

Interaction occurs on an informal basis and appears to be infrequent. There are no formal staff meetings between clinic staff and teachers to discuss concerns and advisement regarding students. Teachers and staff get acquainted by means of the "catch as catch can" system - in the hallways, at the zerox machine, or at drop-in visits either in the office or classroom during passing period. However, there is an informal weekend retreat before school starts each year, organized by the head counselor who is a strong force in the collaboration. The retreat is planned by teachers and attendance is voluntary. The clinic staff are invited and "always attend." This event has served to foster relationships between teachers and clinic staff. Clinic staff are also regular attendees at school student events and school staff count on their presence. The administration reportedly calls upon clinic staff for school emergencies in which students are involved. In spite of the fact that clinic staff relate to and work with faculty and students, there is minimal inter-dependence in terms of a school organization chart.

There is, however, a strong bond that has developed among the professional educators and the non-educator professionals. This relationship among clinic staff, ancillary staff and teachers is described as an "emotional linkage" seemingly based on the shared perception that everyone is focused on the students. "We're here for the kids" was a phrase frequently repeated by both faculty and clinic staff. There is a solidarity among those interviewed that reveals an informal structure created when clinic staff's goals of student well-being convene with teachers' goals of student well-being. Description of this relationship is summarized best by the head counselor.

> "They (clinic staff) are an integral part of our staff even though they are an agency that is not officially, technically part of our school system - and we couldn't do without them."

This response appears to stem from an understanding of common purpose combined with an ethos of caring - both elements which promote the collaboration.

It should be noted that there was one different view expressed. The teacher most strongly opposed to the on site clinic commented.

> I have rather cynical views about these kinds of collaborations. It is not a collaboration between me as a school employee although I do not oppose it. I oppose it philosophically, but I do not actively work to oppose it....I accept it as a presence in the school and I go about my business."

Consequences of Teacher Collaboration: An Emerging Institution

In spite of the lack of a formal structure for collaboration, the fact that the adolescent clinic does not operate under the school's supervision, and some minority opposition to the Teen Health Center on site and clinic staff in the school building, the clinic nevertheless is identified as part of the school, the clinic staff as school staff - a portrayal of a new order. A new pattern is emerging, called into being through a bundle of new scripts and an expanded role constructed by teachers as they seek to make sense out of their circumstances. As the activity sequences are repeated over and over again, collaboration appears to be in the process of becoming institutionalized.

There are four forces that contribute to this impression. The first is that the early conflict and controversy concerning the placement of the clinic on campus has died down denoting acceptance. Symbolically, this factor is stated by one teacher who said, "It's [the clinic is] a non event." The questions associated with the early implementation are for the most part gone. This analysis is consistent with DiMaggio and Powell's (1991) assertion

that "Change when it does occur is likely to be episodic, highlighted by a brief period of crisis or critical intervention and followed by longer periods of stability" (p.197). The second is the constant reminder of the clinic in the front hall with students coming in and out all day long for eight years now. The adolescent health center has a place and a purpose. It is perceived as a relative fixture. One of the veteran teachers summarized, "We have had the clinic here for so long, we just take it for granted."

The third is that it is the teachers who have shown acceptance of the Teen Health Center and have made the collaboration work. Crowson and Boyd (1996, p.265) write "service coordination that is posited from above cannot be sustained if there fails to be a strong bottom-up acceptance of and evidence of success in, the direct implementation of coordinated services." The fourth is that the teachers have constructed new scripts in relationship to students and the adolescent clinic on site. The teachers are establishing patterns of activity that are being reproduced. The process of attainment of these patterns can be described as institutionalization. A new way of working with students has evolved around the co-location of the adolescent clinic at the school. The services provided by clinic staff and the linkages provided by the teachers are integral to the identity of the school.

Conclusions and Implications

This exploratory study describes the role of the teacher in the reform effort to integrate health and social services with schools. While this case study represents the collaboration between a health department co-located at just one school site, some conclusions can be offered and some ideas for further study can be suggested.

While the idea for the city to support the schools originated with the city government and the health department, this inquiry shows that progress towards collaboration occurs at the individual level of teachers, ancillary and clinic staff where services are delivered. The resources for this collaboration are provided by the city in response to overwhelming need for health and social services for adolescents. Societal problems show up in the daily lives of the students and therefore in the classrooms. This situation poses a challenge for teaching. While high school teachers in the past have not made referrals to or interacted with non school personnel in management of students' personal health and social problems, present circumstances have forged a new merger - a crisis collaboration. There is not a new job description issued. Teachers have improvised and created new ways of acting . The repetitious activity of these new scripts and expanded role support the activity of the adolescent clinic and contribute to its persistence. Further research into teachers' actions which contribute to change in institutions might lead to increased understandings regarding the potential of success for this reform effort.

While the change appears to have come from outside of the school, most teachers have accepted the model of the adolescent clinic co-located on the school site based on their perceptions of legitimacy, positive feedback and provision of needed and purposeful services provided by clinic staff. Teachers have responded by being more interactive with their students with regards to health and social concerns. Teachers are identifying students who are stressed and intervening to link them with services provided by the clinic. Teachers also are finding new ways to encourage students who are receiving services because of special needs. Teachers acknowledge and advocate the clinic services. Teachers incorporate these newly constructed scripts built out of caring and concern for students into an expanded role with students and in their engagement with non-educators on behalf of the students. Students are seen coming and going, in and out of the clinic throughout the day, thus giving evidence to bottom up acceptance of new relationships fostered between

educators and non-educators. Policymakers may want to pay attention to the linkage that teachers provide and find ways to build upon and support the teachers' efforts.

This study concentrates on teachers and their informal engagement that supports change - emergence of a new institution called collaboration. Research from the perspective of the health and social service providers would complement this study. Questions to ask might include: How does the clinic staff make sense of their work as health and service providers co-located at a school site? What is their perception of working on the school campus with students during the instructional day? How are they prepared or trained for this assignment? What activities do they perceive as supporting or constraining their efforts? Further qualitative research from the perspective of clinic staff would allow for comparison and contrast to shed further light on the process. Findings could inform administrators and managers of the supports as well as the barriers in implementation of such collaboration. If research could uncover common cultural understandings among collaborators it may be possible to communicate more effectively across the disciplines, thereby, enhancing the chances for success of this movement. In consideration of the possibilities that integrated children's services has to offer, and the movement towards acceptance of this arrangement by teachers, educators may want to intensify the development of curriculum across disciplines for inter-professional training and, in particular, as a component of teacher preparation to strengthen such collaborative efforts.

Neo-institutionalism provides a framework for understanding change and the emergence of an expanded role to create connections at critical points in collaborative efforts. Rather than focusing on constraints, this study reveals that prospects for collaboration of school and community health and social services co-located on the school site can be influenced by teacher construction of new scripts. In turn, effort on the part of

the teachers may hinge on the educators' perception of the interplay between student well-being and learning and teachers' concept of teaching a subject versus teaching the whole child. While teacher engagement appears to be strategic in promoting collaboration, further inquiry into the teachers' perception of the relationship of wellness and academic achievement may be key to understanding possibilities for success of this reform effort.

The teachers' efforts are strategic in the emergence of a new institution - collaboration between the health department and the school. Neo-institutionalism provides a lens with which to analyze the interpenetration of the environment, how actors make sense out of their circumstances and then actively create an order in their working lives. While it may appear that change has not occurred at the structural core of the school's organization, it can be argued that the culture of the school has decidedly changed. This is a school where people have adapted to the idea that school is not just an academic institution but a place concerned and attentive to the health and welfare of students. Evidence from teachers reveals that the mandate has enlarged and is urgent in the face of crisis conditions.

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